*Orange Psychiatric Medical Group, Inc*

## Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by submitting a written request. This authorization will remain in effect until cancelled.

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other ________________________________ |
| Cardholder Name (as shown on card): ________________________________ |
| Card Number: ________________________________ CVV ______________________ |
| Expiration Date (mm/yy): ________________________________ |
| Cardholder ZIP Code (from credit card billing address): ________________________________ |

I,________________________, authorize Orange Psychiatric Medical Group, Inc to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____________________________________ Customer Signature

_____________________________________ Date

_____________________________________ Patient Name

_____________________________________ Date of Birth